MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157)

CERTIFICATE OF DEATH

11303

Reg. Dist. No. 22

1. PLACE OF DEATH:
County: Anne Arundel
City or town: near Laurel
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Laurel, Maryland
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: near Laurel Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: Laurel, Maryland
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Baby girl Adams "B" twin

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	-

6 (b) Name of husband or wife: none
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 31, 1940

8. AGE: Years: - Months: - Days: 3 If less than one day: hrs. min.

9. Birthplace: near Laurel, Anne Arundel Co., Md.
(Town, county, and state)

10. Usual occupation: none

11. Industry or business: none

FATHER
12. Name: George Gross
13. Birthplace: Washington, D. C.

MOTHER
14. Maiden name: Catherine Adams
15. Birthplace: Washington, D. C.

16. Informant: Records of Institution
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 4, 1940 (month) (day) (year)
Cemetery or crematory: Cemetery
Location: District Training School

18. Funeral director: Dr. James Lewald
Address: Laurel, Maryland

19. Nov. 4 1940 (Date rec'd by registrar) Clara M. Hamlet Registrar

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH: November 3 1940, at 2.55 M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 31 1940, to November 3 1940, and that I last saw her alive on November 3 1940.

Immediate cause of death	DURATION
prematurity of birth	
Due to asphyxia due to depression of central respiratory centers	3 das. 9 hrs. 40 min.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations: none
Of autopsy: none

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no
Accident, suicide, or homicide: - Date of:
Where did injury occur?: - (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): -
Means of injury: - Injured at work? -

23. SIGNATURE: F. F. Dugan, M. D. or other
Address: Laurel, Md. Date signed 11/4/40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
DEC 6 1940
U. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (85)

CERTIFICATE OF DEATH

11304

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Crownsville State Hospital
How long in hospital or institution? 2 years, 3 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 2501 McCulloh Street
(If rural, give LOCATION)
2.(a) If veteran, name war: --------

3. (a) FULL NAME: WALTER AMES

3. (b) Social Security Number: ---------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	black	single

6.(b) Name of husband or wife: single
6.(c) If alive, give age: ? years
7. Birth date of deceased (mo., day, yr.): 1906

8. AGE: Years: 34 Months: Unknown Days: If less than one day: ..... hrs. ..... min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: Unknown
11. Industry or business: -----

FATHER
12. Name: Alexander Ames
13. Birthplace: Virginia

MOTHER
14. Maiden name: Louisa Finney
15. Birthplace: Virginia

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 11-4-40 (month) (day) (year)
Cemetery or crematory: Arbuckles Park
Location: A A County

18. Funeral director: Mrs Samuel T. Hensley
Address: 578 W. Biddle St

19. ~~11/21~~ Nov. 18 1940 (Date rec'd by registrar) E. F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 18th 1940 at 5:20A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 18th 1938, to Nov. 18th 1940 and that I last saw him alive on Nov. 18th 1940

Immediate cause of death	DURATION
Epilepsy	
Due to	
Due to	
Other conditions: -----	

(Include pregnancy within 3 months of death)

Major findings of operations: ----
Date of op.
Autopsy results: ----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: ---- Date of
Where did injury occur? ------ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) -----
Means of injury Injured at work?

23. SIGNATURE: Alick P. Harrison M.D. M. D. or other
Address: Crownsville, Md. Date signed: 11/18/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 29 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (2nd) Reg. Dist. No. 21

CERTIFICATE OF DEATH

11305

1. PLACE OF DEATH:
(a) County Anne Arundel
(b) City or town Boulevard Park
(If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days) 38 yrs

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Boulevard Park
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Jacob Eoleon Bailey

3 (b) If veteran, name war

3 (c) Social Security No. none

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Josephine Bailey

6. (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) May I9, I857

8. AGE: Years 83 | Months 6 | Days 5 | If less than one day ____hr. ____min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual occupation Tailor (retired)

11. Industry or business

FATHER
12. Name Wm. Bailey
13. Birthplace Pr. Anne Co., Md.

MOTHER
14. Maiden Name Mary E. Wales
15. Birthplace Talbot Co., Md.

16 (a) Informant Josephine Bailey
(b) Address P.O. Pasadena, Md.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof II-27-40 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel Cem.
Location Lakeshore, A. A. Co., Md.

18 (a) Funeral director Thos. Singleton
(b) Address Glen Burnie, Md.

19 (a) 11-24-40 (Date rec'd by registrar) (b) L. A. Breit Registrar

MEDICAL CERTIFICATION

20. Date of death November 24 1940, at 2 P M

21. I certify that death occurred on the date above atated; that I attended deceased from April 1939, to October 1940, and that I last saw him alive on October 28 1940.

Immediate cause of death Chronic valvular heart disease — Duration indefin.
Arteriosclerosis
Due to
Due to
Other conditions Senility
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L. A. Breit, M. D. or other
Address Pasadena, Md. Date signed 11-24-40

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
DEC 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

11306

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: U.S.NAVAL HOSPITAL, ANNAPOLIS, MARYLAND

Stay in hospital or inst. (yrs., or mos., or days): One(1) Hour

Stay in this community (yrs., or mos., or days): Unknown

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: a.a.

City or town: Bel Air Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Near annapolis Md.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: World War

3. (a) FULL NAME: Jerome Hallett BAKER

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Maude N. BAKER

6(c) If alive, give age: 39 years

7. Birth date of deceased (mo., day, yr.): Dec. 23- 1896

8. AGE: Years: 43 Months: 10 Days: 8 If less than one day: ____ hrs. ____ min.

9. Birthplace: Chelsea. mass. (Town, county, and state)

10. Usual occupation: SHIP'S COOK FIRST CLASS, U.S.N.

11. Industry or business: U.S.NAVY.

FATHER 12. Name: Jerome B Baker

FATHER 13. Birthplace: Halifax Nova Scotia

MOTHER 14. Maiden name: Grace A Hallett

MOTHER 15. Birthplace: Boston Mass

16. Informant: R.M. Shannon R.M. SHANNON, Captain, (MC), U.S.N.

Address: U.S.NAVAL HOSPITAL, ANNAPOLIS, MD.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof: NOV 4-1940 (month) (day) (year)

Cemetery or crematory: Cedar Bluff

Location: annapolis. Md

18. Funeral director: B. F. Watkins

Address: annapolis Maryland

19. 11 4 19 40 (Date rec'd by registrar) J. H. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1-NOVEMBER 1940, at 12:15 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 31-OCTOBER 1940, to 1-NOV. 1940, and that I last saw him alive on 1-NOV. 1940.

	DURATION
Immediate cause of death: CARDIAC FAILURE	
Due to THROMBOSIS, CORONARY ARTERY:	UNKNOWN
Due to	
Other conditions	
(Include pregnancy within 3 months of death)	

Major findings:

Of operations

Of autopsy THROMBOSIS, CORONARY ARTERY.

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: Robert J. Vaughn

Robert J. VAUGHN, Lieut. (MC), U.S.N. (M.D. or other)

Address: U.S. NAVAL HOSPITAL Date signed: 1-Nov. 1940

ANNAPOLIS, MARYLAND

RECEIVED
NOV 14 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11307

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 3 months, 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 911 Harlem Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: ----

3. (a) FULL NAME: WILLIAM BENTLEY

3. (b) Social Security Number: ------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	married

6.(b) Name of husband or wife: Emma Bentley
6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): 1886

8. AGE: Years	Months	Days	If less than one day
54	Unknown		hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Stevedore
11. Industry or business: ----

FATHER
12. Name: Preston Bentley
13. Birthplace: Maryland

MOTHER
14. Maiden name: Agnes Ennals
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-5-1940 (month) (day) (year)
Cemetery or crematory: Mt Auburn Cem.
Location:
18. Funeral director: Mrs. Katie R Williams
Address: 322 N. Schroeder St.
19. Nov 2 1940 (Date rec'd by registrar) E. T. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 1st 1940 at 1:30P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 23rd 1940 to November 1 1940 and that I last saw him alive on Nov. 1st 1940

Immediate cause of death	DURATION
General Paralysis of the insane	
Due to	
Due to: Lues	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ------ Date of op.
Autopsy results: ------
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ------ Date of -----
Where did injury occur? (City or town) (County) (State) ------
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work? -----

23. SIGNATURE: Alick P. Harrison M.D.
Address: Crownsville, Md. M. D. or other
Date signed: 11/1/40

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
DEC 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (95-2)

Reg. Dist. No. 23

11308

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) County a. a. Anne Arundel
(b) City or town Ferndale Ferndale
(If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days) 15 yrs.

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md. (b) County a. a. Anne Arundel
(c) City or town Ferndale Ferndale
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Matilda Garrett Bradshaw

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex Female

5. Color or race Pal.

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Richard Bradshaw

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1865

8. AGE: Years 65 | Months | Days | If less than one day hr. min.

9. Birthplace North Carolina
(Town, county, and state)

10. Usual occupation Midwife

11. Industry or business

FATHER
12. Name ? Garrett
13. Birthplace

MOTHER
14. Maiden Name Martha ?
15. Birthplace

16 (a) Informant Harrison Bradshaw
(b) Address Ferndale Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-26-40 (month) (day) (year)
(c) Cemetery or crematory Rockboro
Location North Carolina

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill ave.

19 (a) 23 Nov 1940 (Date rec'd by registrar) (b) Caldwell Woodruff Registrar

MEDICAL CERTIFICATION

20. Date of death Nov. 22 1940 at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1940, to Nov 22 1940, and that I last saw him alive on Nov 22 1940.

Immediate cause of death	Duration
Cardio Vascular disease	1 week
Cardio vascular disease	1 week
Due to Arterio sclerosis	5 yrs
Due to	5 years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas. L. Bale Jr. M.D.
M. D. or other

Address Linthicum Md. Date signed 11-23-40

Linthicum Heights Nov 23 1940

VS. A15 (I) (T) (M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 26 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

11309

Reg. Dist. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Annapolis Ward No. 3
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 211 Hanover St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Elizabeth Mary Brady

3. (b) Social Security Number

4. Sex Female
5. Color or race White
6. (a) Single, married, widowed, or divorced Single
B (b) Name of husband or wife
6(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) May 23d 1859
8. AGE: Years 81 Months 5 Days 23 If less than one day hrs. min.
9. Birthplace Annapolis Md.
(Town, county, and state)
10. Usual occupation None
11. Industry or business
FATHER 12. Name John W. Brady
13. Birthplace Annapolis Md.
MOTHER 14. Maiden name Annie M. Revell
15. Birthplace Annapolis Md.
16. Informant Mrs Walter L. Wilson
Address 213 Hanover St. Annapolis Md
17. Burial Date thereof Nov 18th 1940
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory St Mary's Cemt
Location Annapolis Md.
18. Funeral director John M. Taylor
Address Annapolis Md.
19. Nov 17 1940 J. J. Murphy
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 16 1940, at 8P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1 1940, to Nov 15 1940, and that I last saw her alive on Nov 15 1940.

Immediate cause of death Myocarditis (Chr) + Myocarditis Snuffering — DURATION 2 years
Due to Arterio Sclerosis — unknown
Due to Uremia — 2 units
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury injured at work?

23. SIGNATURE George C Boul M. D. or other
Address Annapolis Md Date signed 11-17-40

VS A15 MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
DEC 5 1940
BUREAU V. S.

to

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

11310

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel County

City or town: Crownsville State Hospital
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? since Sept. 4. 1940

Hospital, Institution, or street address where death occurred: Crownsville State Hospital

How long in hospital or institution? since Sept. 4. 1940

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Baltimore

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Linden ave, Cherry Heights
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Elizabeth Brown

3.(b) Social Security Number:

4. Sex: f

5. Color or race: col.

6.(a) Single, married, widowed, or divorced: divorced

6.(b) Name of husband or wife: former husband: Braxton

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1877 (?)

8. AGE: Years 63(?) | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace: Md
(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER
12. Name: John Brown
13. Birthplace: Kentucky

MOTHER
14. Maiden name: Anny Johnson
15. Birthplace: Md

16. Informant: file of State Hospital
Address: Crownsville, Md

17. burial
(Burial, cremation, or removal. Which?)
Date thereof: 11/5, 1940 (month) (day) (year)

Cemetery or crematory: Pleasant Hill

Location: Balto Co Md

18. Funeral director: Elroy Willson
Address: 1000 Brantly Ave Balto Md

19. 11/4 1940 21
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 3. 1940 at 12:45 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 4. 1940 to Nov. 3. 1940 and that I last saw her alive on Nov. 3. 1940

Immediate cause of death	DURATION
bronchopneumonia right lung	1 day
Due to	
Due to	
Other conditions: senile psychosis with paranoid trends	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: Alick P. Harrison MD
M. D. or other

Address: Crownsville State Hosp. Date signed: Nov. 3. 40

(M) MARGIN RESERVED FOR BINDING

(I) PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(T) VS A15

RECEIVED
DEC 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11311

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Crownsville State Hospital
How long in hospital or institution? 1 yr. 6 mos. 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1011 Whatcoat Street
(If rural, give LOCATION)
2.(a) If veteran, name war: -----

3.(a) FULL NAME: LOUIS BROWN #2

3.(b) Social Security Number: -------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	single

6.(b) Name of husband or wife: ------
6.(c) If alive, give age: --- years
7. Birth date of deceased (mo., day, yr.): 1902

8. AGE: Years: 38 Months: Unknown Days: If less than one day: ..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Shoe-maker
11. Industry or business: -----
FATHER 12. Name: Edward Brown
13. Birthplace: Maryland
MOTHER 14. Maiden name: Bertha White
15. Birthplace: Maryland
16. Informant: Hospital Records
Address: Crownsville, Maryland
17. burial (Burial, cremation, or removal. Which?) Date thereof: 11/28/40 (month) (day) (year)
Cemetery or crematory: Hospital
Location:
16. Funeral director: Supt.
Address:
19. 11/28 1940 (Date rec'd by registrar) C. F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 20th 1940 at 10:20P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 15th 1939 to Nov. 20th 1940 and that I last saw him alive on Nov. 20th 1940

Immediate cause of death	DURATION
General paralysis of the insane	
Due to	
Due to Lues	
Other conditions ----	

(Include pregnancy within 8 months of death)
Major findings of operations: -----
Date of op.
Autopsy results: -----
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ----- Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) -----
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Crownsville, Md Date signed: 11/20/40

VS A15 MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
DEC 5 1940
BUREAU V. S.

11312

STATE OF MARYLAND
CERTIFICATE OF DEATH

(127-a)

Registration Dist. No. 25

1 PLACE OF DEATH

County A. A. Co

Village or City Riveria Beach (No. Glen Road St.: Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Mary Brown

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Widow

6 DATE OF BIRTH: Oct 28, 1865 (Month) (Day) (Year)

7 AGE: 75 yrs. mos. 10 ds. If LESS than 1 day hrs. or min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country): Poland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (State or country): "

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (State or Country): "

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Anna Brank

(Address) Riveria Beach Md

15 Filed Nov 8 1940 Ida M. Whitson Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Nov 7, 1940 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Oct 15 1940 to Nov 7, 1940, that I last saw her alive on Nov 5, 192, and that death occurred on the date stated above, at 6 25 A. m.

The CAUSE OF DEATH * was as follows:

Broncho Pneumonia

Chronic Cholecystitis

(Duration) yrs. mos. 4 ds.

Contributory Secondary: Chronic Diarrhea

Umbilical Hernia

(Duration) yrs. 6 mos. ds.

(Signed) Leon D. Hopkins M. D.

Nov 7 1940 (Address) 4700 Pearington Baltimore

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Holy Cross Cem. A.A.Co.

DATE OF BURIAL: Nov. 11th 1940

20 UNDERTAKER: Charles F. Dill

ADDRESS: 1501 E. Fort Ave

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

Revised United States Standard Certificate of Death

(Approved by U. S. Census and American Public Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," *etc.* State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

DEC 4 1940

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (8)

CERTIFICATE OF DEATH

11313

Reg. Dist. No. 21

1. PLACE OF DEATH:
County a - a
City or town St Margrets Md
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County a a co
City or town annapolis Md Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Still Infant Cook

3. (b) Social Security Number

4. Sex Fem
5. Color or race Col
6. (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife Gladus Henson
Still Born 6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 19 1940

8. AGE: Years 1940 | Months | Days | If less than one day hrs. min.

9. Birthplace St Margrets Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name Asbury Cook.
13. Birthplace St Margrets. Md

MOTHER
14. Maiden name Gladus Henson.
15. Birthplace St Margret Md.

16. Informant Cristenna Henson
Address St Margrets Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 22 1940 (month) (day) (year)
Cemetery or crematory Henson Family Cent
Location St Margrets Md

18. Funeral director E. H. B. Parker
Address 47 Washington St

19. 11/22 1940 (Date rec'd by registrar) J J Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-19 1940, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Stillbirth 19 to 19
and that I last saw h alive on 19

Immediate cause of death | DURATION
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Lawrence W. Greene, M.D. M. D. or other
Address Annapolis Date signed 11/22/40
Dr Green.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
DEC 5 1940
BUREAU V. S.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-A)

11314

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Crownsville State Hospital

How long in hospital or institution? 3 yrs, 2 mos. 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 302 N. Spring St.,
(If rural, give LOCATION)

2.(a) If veteran, name war: ------

3. (a) FULL NAME: CLARA COOPER

3. (b) Social Security Number: ------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	married

6.(b) Name of husband or wife: Unknown

6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): 1857

8. AGE:

Years	Months	Days	If less than one day
83	Unknown		hrs. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: -----

FATHER
12. Name: Joseph Cooper
13. Birthplace: Unknown

MOTHER
14. Maiden name: Margaret (Unknown)
15. Birthplace: Unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. burial
(Burial, cremation, or removal. Which?)
Date thereof: 12/4/40 (month) (day) (year)

Cemetery or crematory: Mt Calvary (3) Laurel

Location: A. A. County

18. Funeral director: Mrs Ida Bailey
Address: 1421 Jefferson St

19. 11/30-40 19
(Date rec'd by registrar)
E. F. Joyce
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 30th 1940 at 1 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 20th 1937, to Nov. 30th 1940 and that I last saw her alive on Nov. 30th 1940

Immediate cause of death: Chronic myocarditis

Due to:

Due to:

Other conditions: Senility

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations: -----

Date of op.

Autopsy results: -----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: --- Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): -----

Means of injury: Injured at work? -----

23. SIGNATURE: [signature] M. D. or other

Address: Crownsville, Md. Date signed: 11/30/40

RECEIVED
DEC 3 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30-2

CERTIFICATE OF DEATH

11315

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 1 yr. 5 mos. 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Unknown
(If rural, give LOCATION)
2.(a) If veteran, name war: -------

3.(a) FULL NAME: ROBERT CREST

3.(b) Social Security Number: ---------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	black	single

6.(b) Name of husband or wife: ---------
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1879

8. AGE: Years	Months	Days	If less than one day
61	Unknown		hrs. min.

9. Birthplace: North Carolina
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: -----

FATHER
12. Name: Samuel Crest
13. Birthplace: North Carolina

MOTHER
14. Maiden name: Sarah Crest
15. Birthplace: North Carolina

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. (Burial, cremation, or removal. Which?) burial Date thereof Nov. 22 1940 (month) (day) (year)
Cemetery or crematory: Hospital
Location:

18. Funeral director: Dept.
Address:

19. (Date rec'd by registrar) Nov 22 1940 E. F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 8th 1940 at 7:10P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 22nd 1939 to Nov. 8th 1940 and that I last saw him alive on Nov. 8th 1940

Immediate cause of death	DURATION
Chronic myocarditis due to syphilis	
Due to	
Due to	
Other conditions -----	

(Include pregnancy within 3 months of death)

Major findings of operations: -------
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ------- Date of:
Where did injury occur? ------- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): --------
Means of injury: Injured at work? ----

23. SIGNATURE: Alex P. Harrison M.D. M. D. or other
Address: Crownsville, Md. Date signed 11/8/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

RECEIVED
DEC 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8)

CERTIFICATE OF DEATH

11316

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Barlyheights
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Barlyheights md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Still Birth (Infant Boy)

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col	

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov 8 1940

8. AGE: Years	Months	Days	If less than one day
			..... hrs. ..... min.

9. Birthplace: Barlyheights Md. (Town, county, and state)
10. Usual occupation
11. Industry or business

FATHER
12. Name: Melvin Thomas Berry
13. Birthplace: Anne Arundel Co

MOTHER
14. Maiden name: Margaret Parker
15. Birthplace: Annapolis md.

16. Informant: Margaret Parker
Address: Barlyheights md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 9 1940 (month) (day) (year)
Cemetery or crematory: Brewer Lot
Location: On Washington rd near Annapolis
18. Funeral director: Charles H. Alexander
Address: 43 and 45 Northwest st Annapolis Md.
19. 11/9 1940 (Date rec'd by registrar) J. M. Murray Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 8 1940 at 6:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 8 1940
and that I last saw him alive on 19
Immediate cause of death: Still Born (Prematurity)

	DURATION
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Dr. R. L. Richardson M. D. or other
Address: Annapolis, Md. Date signed: 11/9/40

RECEIVED
DEC 5 1940
BUREAU V. S.

11317

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8)

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Earlyheights
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Earlyheights Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Still Birth (Infant Day)

3. (b) Social Security Number

4. Sex: Female
5. Color or race: Col.
6.(a) Single, married, widowed, or divorced
6.(b) Name of husband or wife
6.(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.): Nov 8, 1940

8. AGE: Years | Months | Days | If less than one day ____ hrs. ____ min.

9. Birthplace: Earlyheights Md.
(Town, county, and state)
10. Usual occupation
11. Industry or business

FATHER
12. Name: Melvin Thomas Day
13. Birthplace: Anne Arundel Co.

MOTHER
14. Maiden name: Margeret Parker
15. Birthplace: Annapolis Md.

16. Informant: Margeret Parker
Address: Earlyheights Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 9 1940 (month) (day) (year)
Cemetery or crematory: Brewer Hill
Location: on Washington rd. near Annapolis

18. Funeral director: Charles H. Alexander
Address: 43 and 45 Northwest

19. 11/9 1940 (Date rec'd by registrar) J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 8 1940, at 6:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Only on 19 Nov 8 1940
and that I last saw h alive on 19

Immediate cause of death: Still Born (Prematurity)

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: R. L. Richardson M. D. or other
Address: Annapolis, Md. Date signed 11/9/40

VS A15 MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
DEC 5 1940
U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (152)

11318

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel County

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1mo. 2days

Hospital, institution, or street address where death occurred: Crownsville State Hospital

How long in hospital or institution? 1 mo. 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: ~~New Castle, Delaware~~
(If outside city or town limits, write RURAL and give nearest town)

Street No.: ~~110 E. Fourth Street~~
(If rural, give LOCATION)

2.(a) If veteran, name war: ---------

3.(a) FULL NAME

Mary F. Dutton

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Black	Married

6.(b) Name of husband or wife: Unknown

6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): 1864

8. AGE: Years: 75 Months: Unknown Days: If less than one day: ___ hrs. ___ min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: ---------

FATHER
12. Name: Edward Hilton
13. Birthplace: Maryland

MOTHER
14. Maiden name: Elizabeth (Unknown)
15. Birthplace: Maryland

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. November 28, 1940 Date thereof (month) (day) (year)
(Burial, cremation, or removal. Which?) CLARKS CHAPEL

Cemetery or crematory: ~~Chestnut Hill~~

Location: Harford County

18. Funeral director: Charles E. Gross

Address: Benson, Maryland

19. Nov 25 1940 (Date rec'd by registrar) E. F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 24 1940, at 4 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 22 1940, to Nov. 24 1940 and that I last saw her alive on November 24 1940

Immediate cause of death: Septicernia

Due to: Primary Cause: Cellulitis, right arm. Probably due to infection of superficial

Due to: ---------- skin lacerations. C.W.G.R. No injury.

Other conditions: ------ Duration: five days.

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations: ------

Date of op.

Autopsy results: -----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: --- Date of: ---

Where did injury occur? -- (City or town) -- (County) -- (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Alex P. Harrison M.D. M. D. or other

Address: Crownsville, Md. Date signed: 11/25/40

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

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RECEIVED
DEC 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-E

CERTIFICATE OF DEATH

Reg. Dist. No. 21 — 11319

1. PLACE OF DEATH:

County: A. A

City or town: Annapolis Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, institution, or street address where death occurred:
Emergency Hospital

How long in hospital or institution? 3 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: A. A.

City or town: Waterbury Md
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: No

3. (a) FULL NAME: Samuel P Forney

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
m	w	married

6.(b) Name of husband or wife: Bertha E. Forney

6.(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): Oct 26 — 1872

8. AGE:

Years	Months	Days	If less than one day
68		13	hrs. min.

9. Birthplace: Balto. Md (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business:

FATHER
12. Name: Jacob I Forney
13. Birthplace: Balto. Md.

MOTHER
14. Maiden name: Eliza J. Baker
15. Birthplace: Balto. Md.

16. Informant: Bertha E Forney
Address: Waterbury Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 10-40 (month) (day) (year)

Cemetery or crematory: Baldwin Memorial

Location: Millersville Md

18. Funeral director: B. L. Hopkins

Address: Annapolis Md.

19. Nov 18 1940 (Date rec'd by registrar) J. J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 8 1940 at 4.20 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug 8 1940 to Nov. 7 1940 and that I last saw h. l. M. alive on Nov. 7 1940

Immediate cause of death	DURATION
Carcinoma of Sigmoid	not known
Due to	
Due to	
Other conditions: Chronic Myocarditis; Chronic interstitial Nephritis (Include pregnancy within 3 months of death)	3 year or more

Major findings of operations: / Date of op. /

Autopsy results: /

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: / Date of /

Where did injury occur? / (City or town) / (County) / (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: John M. Claffy M. D. or other

Address: Annapolis Date signed: 11/9/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
DEC 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (89-a)

CERTIFICATE OF DEATH

11320

Reg. Dist. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis (R.F.D.) Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 93 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. near Water Works
(If rural, give LOCATION)
2.(a) If veteran, name war None

3.(a) FULL NAME Mary M. Gomoljak

3.(b) Social Security Number None

4. Sex female
5. Color or race White
6.(a) Single, married, widowed, or divorced married
6.(b) Name of husband or wife Joseph Gomoljak
6.(c) If alive, give age 69 years
7. Birth date of deceased (mo., day, yr.) Aug. 15, 1874

8. AGE: Years 66 | Months 3 | Days 5 | If less than one day ..... hrs. ..... min.

9. Birthplace Hungary (town, county, and state)
10. Usual occupation Housekeeper
11. Industry or business Home
FATHER 12. Name Peter Muranski
FATHER 13. Birthplace Hungary
MOTHER 14. Maiden name Unknown
MOTHER 15. Birthplace Unknown
16. Informant Joseph Gomoljak
Address Annapolis (R.F.D.), Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 23-40 (month) (day) (year)
Cemetery or crematory St. Mary's
Location Annapolis, Md
16. Funeral director L. L. Hopkins
Address Annapolis Maryland
19. 11-22-1940 (Date rec'd by registrar) J. J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 20 1940 at 4 00 P. M
21. I CERTIFY that death occurred on the date above stated: ~~Natural Death Accident~~ Post mortem Examination
~~about the hour of 2 o'clock on~~ Nov 20 1940

	DURATION
Immediate cause of death: Cerebral Hemorrhage	Sudden
Due to: Arterio-sclerosis	3 years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John M. Claffy Deputy Medical examiner. M. D. or other
Address Annapolis, Md Date signed 11/20/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
DEC 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11321

Reg. Diat. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)

Street No. Unknown
(If rural, give LOCATION)

2.(a) If veteran, name war: ------

3. (a) FULL NAME

Joseph Harris

3. (b) Social Security Number

------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	Unknown

6.(b) Name of husband or wife: --------

6.(c) If alive, give age: ---------- years

7. Birth date of deceased (mo., day, yr.): 1895

8. AGE: Years	Months	Days	If less than one day
45	Unknown		....hrs. ....min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation: Unknown

11. Industry or business: -----

FATHER
12. Name: James Harris
13. Birthplace: Unknown

MOTHER
14. Maiden name: Emma Faulson
15. Birthplace: Unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/28-40 (month) (day) (year)

Cemetery or crematory: Hospital

Location:

18. Funeral director: Dept

Address:

19. 11/28 40 (Date rec'd by registrar) E. F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 25th 1940 at 10A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 4th 1940 to Nov. 25th 1940 and that I last saw him alive on Nov. 25th 1940

Immediate cause of death	DURATION
General paralysis of the insane	
Due to	
Due to	
Other conditions: Osteomyelitis of the left great toe	

(Include pregnancy within 3 months of death)

Major findings of operations: ------

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: -

Accident, suicide, or homicide. Date of -

Where did injury occur? (City or town) (County) (State) -

Injured at home, farm, industry, public place (where?) -

Means of injury: Injured at work? -

23. SIGNATURE: Clark V. Anderson M. D. or other

Address: Crownsville, Md Date signed: 11/25/40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
DEC 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (46-B)

11322

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Crownsville State Hospital
How long in hospital or institution? 19 yrs. 2 mos. 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 408 Fairmont St., ~~Towson, Md~~
(If rural, give LOCATION)
2.(a) If veteran, name war: ---

3.(a) FULL NAME: MARY JOSEPHINE HENRY

3.(b) Social Security Number: ---

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	black	single

6.(b) Name of husband or wife: ---
6.(c) If alive, give age: --- years
7. Birth date of deceased (mo., day, yr.): 1878

8. AGE: Years: 62 Months: Unknown Days: If less than one day: hrs. min.

9. Birthplace: Tenna. (Town, county, and state)
10. Usual occupation: School-teacher
11. Industry or business: ---
FATHER 12. Name: Joseph Henry, dead
13. Birthplace: North Carolina
MOTHER 14. Maiden name: Mary E. Henry (Williams)
15. Birthplace: Virginia
16. Informant: Hospital Records
Address: Crownsville, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 29-40 (month) (day) (year)
Cemetery or crematory: Mt. Auburn
Location: Balto. Md.
18. Funeral director: Mrs Frances B. Hensley
Address: 578 W. Biddle St. Balto. Md.
19. Nov. 26 19 40 (Date rec'd by registrar) E. F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 25th 19 40 at 8:40 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 15th 19 24 to Nov. 25th 19 40 and that I last saw her alive on Nov. 25th 19 40

Immediate cause of death	DURATION
Carcinoma ventriculi with general carcinose of the peritoneum	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations: ---
Date of op.
Autopsy results: ---
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ---- Date of
Where did injury occur? ---- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ----
Means of injury: Injured at work? ----

23. SIGNATURE: [signature] M. D. or other
Address: Crownsville, Md Date signed: 11/25/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
DEC 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8)

CERTIFICATE OF DEATH

11323

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County a-a-
City or town Annapolis Md
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 44 Washington St
Stay in hospital or inst. (yrs., or mos., or days) —
Stay in this community (yrs., or mos., or days) —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County a-a
City or town Annapolis Md Ward No. 4
(If outside city or town limits, write RURAL NEAR and give town)
Street No. — — — —
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME Still Infant Hicks

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	Single

6 (b) Name of husband or wife —
6(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 11 1

8. AGE:

Years	Months	Days	If less than one day
1/40			Still Born hrs. min.

9. Birthplace Annapolis Md
(Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER
12. Name Harvy Hicks
13. Birthplace Annapolis Maryland

MOTHER
14. Maiden name Rose Lee Cully
15. Birthplace Annapolis Md

16. Informant Harvy Hicks
Address 44 Washington St

17. Brewerhill Cmt (Burial, cremation, or removal. Which?) Date thereof 11 2 1940 (month) (day) (year)
Cemetery or crematory Brewerhill Cmt
Location Annapolis Md

18. Funeral director E.H.Barker
Address 47 Washington St

19. 11/2 (Date rec'd by registrar) 1940 J J Murphy Jr (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 1 1940, at 3 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1 1940, to — 19—, and that I last saw h— alive on — 19—.

Immediate cause of death	DURATION
Premature birth	Unknown
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy —

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work?

23. SIGNATURE Ambrose Garcia MD
M. D. or other
Address Annapolis Md Date signed 11-2-40

Garcia

RECEIVED
DEC 5 1940
BUREAU V. S.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13E)

11324

CERTIFICATE OF DEATH

Reg. Dist. No. 22

1. PLACE OF DEATH:

County A. A.

City or town Severn (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County A. A.

City or town Severn (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME James Hood

3. (b) Social Security Number None

4. Sex M

5. Color or race White

6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Pearl Hood

6.(c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) October 15th 1881

8. AGE: Years 59 Months 1 Days 6 If less than one day ..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name Paul Hood

13. Birthplace Maryland

MOTHER 14. Maiden name Mary Hood

15. Birthplace Maryland

16. Informant Mrs Pearl Hood

Address Severn Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 25th 1940 (month) (day) (year)

Cemetery or crematory Cedar Hill

Location Brooklyn Md

18. Funeral director Lloyd Kaiser

Address Laurel Md.

19. Nov 22 1940 (Date rec'd by registrar) N. L. Jones D.L. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 22 1940, at 2 45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 5 1940, to Nov 22 1940 and that I last saw him alive on Nov 19 1940

Immediate cause of death Pulmonary Intervention

DURATION

Due to

Due to

Other conditions Cardio Sclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Joseph Lipsky M. D. or other

Address Aldenton Md Date signed Nov 22-40

RECEIVED
DEC 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (131-a)

11325

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH:
County A. A. Co.
City or town Mayo
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 38 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County A. A.
City or town Mayo Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Sarah Lavinia Horsman

3. (b) Social Security Number

4. Sex F
5. Color or race W
6. (a) Single, married, widowed, or divorced Widow
6 (b) Name of husband or wife Wm. Jefferson Horsman
6(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) August 12 1855

8. AGE: Years 85 Months 2 Days 25 If less than one day hrs. min.

9. Birthplace Baltimore City
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name Edward Ward
13. Birthplace Baltimore City
MOTHER 14. Maiden name Lavinia Dorsey
15. Birthplace Calvert Co. Md.
16. Informant Webster F. Horsman
Address Edgewater R.F.D.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 11 9 40 (month) (day) (year)
Cemetery or crematory Mayo Methodist Memorial
Location Mayo, Md
18. Funeral director T. A. Hardisty & Son
Address Galesville, Md
19. Nov 9 1940 (Date rec'd by registrar) Edward Collinson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/7 1940, at 5:30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 5 1940, to Nov 7 1940, and that I last saw her alive on Nov 6 1940.

Immediate cause of death — DURATION
Cerebral Hemorrhage — 11/5/40
Due to Chr. Nephritis & Hypertension — ?
Due to
Other conditions Senility
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Maurice F. Klawans, Md M. D. or other
Address 31 Smith Gate Av Date signed 11/8/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 6 1941
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11326

Reg. Dist. No. 21

1. PLACE OF DEATH
County Anne Arundel
City or town Annapolis (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Unknown
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Annapolis (If outside city or town limits, write RURAL and give nearest town)
Street No. 105 S. Par. Rd. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME George Washington Johnson Sr.

3.(b) Social Security Number 214-05-1932

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	Married

6.(b) Name of husband or wife: Maggie Johnson
6.(c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): July 16 1885

8. AGE: Years	Months	Days	If less than one day
55	7	28	hrs. min.

9. Birthplace: Anne Arundel (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business:
FATHER 12. Name: John Johnson
13. Birthplace: Anne Arundel Co.
MOTHER 14. Maiden name: Adline Cook
15. Birthplace: Anne Arundel Co.
18. Informant: Maggie Johnson
Address: 105 S. Par. Rd Annapolis Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 17, 1940 (month) (day) (year)
Cemetery or crematory: Bremer Hill
Location: On Washington Blvd outside
18. Funeral director: Chas. H. Alexander Annapolis Md
Address: 43 and 45 Northwest
19. Nov 17 1940 (Date rec'd by registrar) Annapolis Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 14 1940 at 10:15 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 6 1940 to November 14 1940
and that I last saw him alive on November 13 1940

Immediate cause of death	DURATION
Lobar Pneumonia	8 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE Lawrence A. Greene M.D. M. D. or other
Address Annapolis, Md. Date signed 11/15/40

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
DEC 5 1940
BUREAU V. S.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8)

11327

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne Arundel

City or town Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Emergency Hospt.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. St Margarets A.A. Co.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Baby Kiles

3. (b) Social Security Number

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov 24th 1940

8. AGE: Years | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Annapolis Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name Frank H. Kiles
13. Birthplace Washington D.C.

MOTHER
14. Maiden name Annie Stokes
15. Birthplace A. A. Co Md.

16. Informant Frank H. Kiles
Address St Margarets A.A.Co Md.

17. Burial (Burial, cremation, or removal (Which?)) Date thereof Nov 1940 (month) (day) (year)

Cemetery or crematory Cedar Bluff

Location Annapolis Md

18. Funeral director John M. Taylor
Address Annapolis Md.

19. 11 26 1940 (Date rec'd by registrar) J. J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 24 1940, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Still 19 Birth 19

and that I last saw h ..... alive on 19

Immediate cause of death ..... DURATION

Due to Still Birth from Premature separation of placenta

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George C Bond M. D. or other

Address Annapolis Md Date signed 11-25-40

RECEIVED
DEC 5 1940
V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30-b

11328

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 1 yr. 10 mos. 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 818 Lemon Street
(If rural, give LOCATION)
2.(a) If veteran, name war: -----

3.(a) FULL NAME: MARY LUCKETT

3.(b) Social Security Number: -------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	married

6.(b) Name of husband ~~if wife~~: William Luckett
6.(c) If alive, give age: ?

7. Birth date of deceased (mo., day, yr.): 1899

8. AGE: Years: 41 | Months: Unknown | Days | If less than one day: ....hrs. ....min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business: -----
FATHER 12. Name: Louis Blake
FATHER 13. Birthplace: Maryland
MOTHER 14. Maiden name: Mary Goffe
MOTHER 15. Birthplace: Maryland
16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 9 1946 (month) (day) (year)
Cemetery or crematory: Mt Calvary
Location: A A Co Md
18. Funeral director: Josiah L Brown Son
Address: 1056 Monty omery St

19. 11-5-40 (Date rec'd by registrar) 19.... E. F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 5th 19 40 at 5:15A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 15 19 38 to Nov. 5th 19 40 and that I last saw h er alive on November 5th, 19 40

Immediate cause of death	DURATION
General paralysis of the insane	
Due to	
Due to Lues	
Other conditions -------	

(Include pregnancy within 3 months of death)

Major findings of operations: -------
Date of op.:
Autopsy results: ------
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ----- Date of:
Where did injury occur? ------ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): -----
Means of injury: Injured at work? ----

23. SIGNATURE: Alex P Harrison MD - M. D. or other
Address: Crownsville, Md. Date signed: 11/5/40

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
NOV 7 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11329

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 5 years 4 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George's
City or town: Mitchellsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Unknown
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: CHRISTINE MARSHALL

3.(b) Social Security Number: ------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	separated

6.(b) Name of husband XXXX Unknown
6.(c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.): 1871

8. AGE: Years	Months	Days	If less than one day
69	Unknown		....hrs. ....min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: ------

FATHER
12. Name: Michael Jones
13. Birthplace: Maryland

MOTHER
14. Maiden name: Winnie (Unknown)
15. Birthplace: Maryland

18. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 12, 1940 (month) (day) (year)
Cemetery or crematory St. Josephs Cemetery
Location Upper Marlboro, Md.
18. Funeral director J B Johnson
Address Annapolis, Md.
19. 11 12 1940 (Date rec'd by registrar) J J Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 8th 1940 at 4:30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 9th 1935 to Nov. 8th 1940 and that I last saw her alive on Nov. 8th 1940

Immediate cause of death	DURATION
Tuberculosis spondylitis	
Due to	
Due to	
Other conditions Tuberculosis of left lung	

(Include pregnancy within 3 months of death)

Major findings of operations: ------
Date of op.
Autopsy results: ------
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ------ Date of
Where did injury occur? ------ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ------
Means of injury Injured at work? ------

23. SIGNATURE Alex P Harrison M.D. M. D. or other
Address Crownsville, Md. Date signed 11/8/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
DEC 5 1940
U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11330

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Eastport
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Eastport
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Horn Point
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: J. Willis Martin

3.(b) Social Security Number:

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Mary Elizabeth Martin
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): December 26th 1894
8. AGE: Years: 45 Months: 10 Days: 9 If less than one day: hrs. min.
9. Birthplace: Annapolis (Town, county, and state)
10. Usual occupation: Medical Director
11. Industry or business
FATHER 12. Name: John W. Martin
13. Birthplace: Annapolis Md.
MOTHER 14. Maiden name: Phebe Brown
15. Birthplace: Annapolis Md.
16. Informant: Mary E. Martin
Address: Eastport A.A.C. Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 7. 1940 (month) (day) (year)
Cemetery or crematory: St Annes
Location: Annapolis Md.
18. Funeral director: John M Taylor
Address: Annapolis Md.
19. Nov 7th 1940 (Date rec'd by registrar) J. M. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 5, 1940, at 1 A.M. M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 25 1940, to Nov. 5 1940
and that I last saw him alive on Nov 5 1940

	DURATION
Immediate cause of death: Brain tumor Rt. frontal lobe	Unknown
Due to: Malignant Glioma, Spongioblastoma multiforme, Cyst R.	
Due to:	
Other conditions: Chronic Bronchitis	Unknown

(Include pregnancy within 3 months of death)

Major findings of operations: As above Operation was performed at University Hospital, Baltimore Md. Date of op.
Autopsy results: Cyst R.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Albert L. Anderson M. D. or other
Address: Annapolis, Md. Date signed: 11/5/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 15 1940
BUREAU V.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

11331

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? since 9.30.40
Hospital, Institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? since 9.30.40

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2414 Annapolis ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Mary Rebecca Morris

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
f	col.	married

6.(b) Name of husband or wife: Joseph Morris
6.(c) If alive, give age: unknown

7. Birth date of deceased (mo., day, yr.): 1876

8. AGE: Years	Months	Days	If less than one day
64	unknown		....hrs. ....min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: housewife
11. Industry or business:

FATHER
12. Name: Bill Smith ?
13. Birthplace: unknown

MOTHER
14. Maiden name: Mary ?
15. Birthplace: unknown

18. Informant: Dr. of Crownsville State Hosp.
Address:

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Nov. 25 1940 (month) (day) (year)
Cemetery or crematory: Mt Auburn Cem.
Location: Balto Md

18. Funeral director: Mrs. Katie R. Williams
Address: 3224 N. Schroeder St

19. 11/21, 1940 (Date rec'd by registrar) E. T. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 21. 1940 at 8:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9.30 1940 to Nov. 21. 1940 and that I last saw her alive on Nov. 20. 1940

Immediate cause of death	DURATION
chronic myocarditis	about 12 days
Due to	
Due to	
Other conditions: senile psychosis with deterioration	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Alex P. Harrison M.D.
M. D. or other
Address: Date signed:

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
DEC 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11332

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 1 yr. 2 months 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1721 N. Franklin Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ------

3.(a) FULL NAME: RICHARD MOULTON

3.(b) Social Security Number: ------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	married

6.(b) Name of ~~Husband or Wife~~: wife Hester Moulton
6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): 1900

8. AGE: Years	Months	Days	If less than one day
40	Unknown		....hrs. ....min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Dry-cleaner
11. Industry or business: -----

FATHER
12. Name: Richard Moulton, dead
13. Birthplace: Maryland

MOTHER
14. Maiden name: Sarah Morrison
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof November 8, 1940 (month) (day) (year)
Cemetery or crematory: Arbutus Memorial Park
Location: Halethorpe, Maryland

18. Funeral director: Mrs. Katie Williams
Address: Baltimore, Maryland

19. 11/6-40 (Date rec'd by registrar) 19.... E. F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 4th 19 40 at 10:40 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 21st 19 39 to Nov. 4th 19 40
and that I last saw h...im alive on Nov. 4th 19 40

Immediate cause of death	DURATION
General paralysis of the insane	
Due to	
Due to Lues	

Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: -----
Date of op.
Autopsy results: -----
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ---- Date of
Where did injury occur? ----- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) -----
Means of injury Injured at work? -----

23. SIGNATURE: Alex P. Harrison M.D.
Address: Crownsville, Maryland M. D. or other
Date signed: 11/4/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 14 1940
BUREAU V.S.

VS A15 MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

11333

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 84 Conduit St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: James M. Murphy

3.(b) Social Security Number

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Single

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): Sept 25th 1912

8. AGE: Years: 28 Months: 2 Days: 0 If less than one day ... hrs. ... min.

9. Birthplace: Annapolis Md.
(Town, county, and state)

10. Usual occupation: none (invalid for 15 yrs.)

11. Industry or business

FATHER
12. Name: John F. Murphy
13. Birthplace: Worchester Mass.

MOTHER
14. Maiden name: Ruth Boucher
15. Birthplace: Annapolis Md

16. Informant: John F. Murphy
Address: 84 Conduit St. Annapolis Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 27 1940 (month) (day) (year)

Cemetery or crematory: Naval Cemetery

Location: Annapolis Md.

18. Funeral director: John M. Taylor
Address: Annapolis Md.

19. 11-26 1940 (Date rec'd by registrar) J. J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 25 1940, at 5:10 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 22 1940, to Nov 25 1940 and that I last saw him alive on Nov 25 1940

Immediate cause of death: G. Myocarditis — DURATION: Several yrs.

Due to: Pseudo Muscular Hypertrophy

Due to: 22 yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE: Oliver Purvis M. D. or other

Address: Annapolis Md. Date signed 11/25/40

RECEIVED
DEC 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

11334

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: A.A

City or town: Mulberrey Hill Road Bay Lodge

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5Years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: A.A.e

City or town: Rural near Annapolis, Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Groonberry Point

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Anna R. Panetti

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: Jacob F. Panetti M

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug 19 1869

8. AGE: Years	Months	Days	If less than one day
71	2	15	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER — 12. Name: James McKnight

13. Birthplace: Nassaugh England

MOTHER — 14. Maiden name: Anna E. McCauley

15. Birthplace: Baltimore, Md

16. Informant: Jacob F. Panetti Jr

Address: Annapolis, R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov6 1940 (month) (day) (year)

Cemetery or crematory: Loudon Park

Location: Baltimore, Md.

18. Funeral director: B.L.Hopping

Address: Annapolis, Md.

19. 11-6 1940 (Date rec'd by registrar) J.J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 3 1940, at 9 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1938, to Nov 3 1940

and that I last saw her alive on Nov 3 1940

Immediate cause of death	DURATION
Cerebral Hemorhage	Nov 3
Due to Hypertension	Unknown
Due to Arteriosclerosis	Unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: George C Boxil M. D. or other

Address: Annapolis Md Date signed 11-5-40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
DEC 5 1940
U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (928)

CERTIFICATE OF DEATH

11335

Reg. Dist. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town East Port Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? about 7 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town East port
(If outside city or town limits, write RURAL and give nearest town)
Street No. 712 Second St
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Anna H. Queen
3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	Col	Widow

6.(b) Name of husband or wife: Zebedee Queen
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): March 17. 1871

8. AGE: Years	Months	Days	If less than one day
69	8.	9	..... hrs. ..... min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name Cosmo Robinson
13. Birthplace St Marys County Md

MOTHER
14. Maiden name Unknown
15. Birthplace "

16. Informant Reba Booth
Address 712 - 2nd St Eastport Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 1 1940 (month) (day) (year)
Cemetery or crematory Mt Auburn
Location Baltimore Md
18. Funeral director Chas. H. Alexander
Address 43-45 Northwest St. Annapolis Md
19. 11-30 1940 (Date rec'd by registrar) J. D. Wright Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 26 1940, at 5 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 29 1940 to Nov 26 1940
and that I last saw h.. alive on Nov 25 1940

Immediate cause of death	DURATION
Heart Failure	Immediate
Due to: Mitral Regurgitation	2 Months
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE S Ambrose Garcia M. D. or other
Address 35 Northwest St Date signed

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
DEC 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11336

Reg. Dist. No. 23

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? C
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 10 months, 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1225 Ashland Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: ---

3. (a) FULL NAME LEONARD RANDOLPH

3. (b) Social Security Number ---

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	black	married

6.(b) Name of husband or wife: Lucille Randolph
6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): 1896

8. AGE: Years	Months	Days	If less than one day
44	Unknown		...hrs. ...min.

9. Birthplace: Unknown (Town, county, and state)
10. Usual occupation: Unknown
11. Industry or business: Unknown
FATHER 12. Name: Unknown
FATHER 13. Birthplace: Unknown
MOTHER 14. Maiden name: Unknown
MOTHER 15. Birthplace: Unknown
16. Informant: Hospital Records
Address: Crownsville, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof: November 18, 1940 (month) (day) (year)
Cemetery or crematory: U.S. Baltimore Nat Cemetery
Location: Baltimore City Maryland
18. Funeral director: Mrs Lottie Groves per JPS
Address: 1408 Ashland ave Baltimore Md
19. NOV 19 1940 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 12th 1940 at 12 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 15th, 1940 to Nov. 12th 1940 and that I last saw him alive on Nov. 12th 1940

Immediate cause of death	DURATION
General paralysis of the insane	
Due to	
Due to	
Other conditions: Lues	

(Include pregnancy within 3 months of death)

Major findings of operations: ---
Date of op.
Autopsy results: ---
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: --- Date of
Where did injury occur? --- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work? ---

23. SIGNATURE: Alex P Harrison M.D.
Address: Crownsville, Md. M. D. or other
Date signed: 11/12/40

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
NOV 16 1940
BUREAU V. S.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157-9)

11337

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel Co

City or town: Friendship Md

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: A-A Co

City or town: Nutwell Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: —

3. (a) FULL NAME: Earl William Riggs

3. (b) Social Security Number: —

4. Sex: Male

5. Color or race: Col

6. (a) Single, married, widowed, or divorced: Single

8 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Aug 1 1940

8. AGE: Years | Months: 3 | Days: 17 | If less than one day: hrs. min.

9. Birthplace: Friendship (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name: James Riggs

13. Birthplace: A.A. Co.

MOTHER

14. Maiden name: Maggie Jackson

15. Birthplace: A.A. Co

16. Informant: Carrie Johnson

Address: Nutwell P.O. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 20 1940 (month) (day) (year)

Cemetery or crematory: Union Chapel

Location: Mt. Rindge Md

18. Funeral director: H.A. Hardesty & Son

Address: Galesville Md.

19. Nov 19 1940 (Date rec'd by registrar) J. J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 18 1940, at 10:45 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/15 1940, to Nov 18 1940, and that I last saw him alive on 10/18/1940.

Immediate cause of death: Starvation. Inanition

Due to: Pyloric Stenosis pathol

Due to: General Adhesion Peritonitis

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy: Adhesion Peritonitis

DURATION: since birth

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: J. Oliver Purvis M. D. or other

Address: Annapolis Md Date signed: Nov 19/40

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DEC 5 1940
REAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

11338

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Crownsville State Hospital
How long in hospital or Institution? 11 months, 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Ferndale
(If outside city or town limits, write RURAL and give nearest town)
Street No. -----
(If rural, give LOCATION)
2.(a) If veteran, name war -----

3.(a) FULL NAME: HARRIETT ROBINSON

3.(b) Social Security Number: ------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	black	widowed

6.(b) Name of husband or wife: ~~xxx~~ Unknown
6.(c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.): 1865

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
75	Unknown			

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business: ~~xxxxxxx~~

FATHER
12. Name: ~~James Ross~~
13. Birthplace: Maryland

MOTHER
14. Maiden name: Isa (Unknown)
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 24, 1940 (month) (day) (year)
Cemetery or crematory: Furnace Branch Cemetery
Location: Furnace Branch, A.A.Co

18. Funeral director: Isiah Brown & Son
Address: 108 W. Montgomery St., Balto.

19. Nov. 22 1940 E. T. Joyce Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 20th 1940, at 3:05P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Nov. 27th 1939, to Nov. 20th 1940
and that I last saw her alive on Nov. 20th 1940

Immediate cause of death	DURATION
Cerebral hemorrhage	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: -----
Date of op.
Autopsy results: ------
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: -----
Date of -----
Where did injury occur? (City or town) (County) ----- (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work? ------

23. SIGNATURE: Ward L. Armbruster M. D., or other
Address: Crownsville, Md. Date signed: 11/20/40

RECEIVED
DEC 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (184)

CB

11339

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: AA Co. near South Haven Beach AA Co.

City or town: —

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Emergency Hospital - Dead on Arrival

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): Unknown

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: District Columbia County:

City or town: Washington Ward No.:

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 2309 Wisconsin Ave N.W.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: ✓

3. (a) FULL NAME: Wallace Frederick Robinson Jr.

3. (b) Social Security Number:

4. Sex: M.

5. Color or race: W

6. (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: none

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 12th, 1925

8. AGE: Years 15 7/12 Months 7 Days 29 If less than one day: hrs. min.

9. Birthplace: Washington, D.C. (Town, county, and state)

10. Usual occupation: Student

11. Industry or business:

FATHER 12. Name: Wallace Frederick Robinson

13. Birthplace: Virginia

MOTHER 14. Maiden name: Luella Whaley

15. Birthplace: Philadelphia, Pa.

16. Informant: Wallace F. Robinson

Address: 2309 Wisconsin Ave. N.W. Washington, D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: November 14th, 40. (month) (day) (year)

Cemetery or crematory: Washington National Cemetery

Location: Washington, D.C.

18. Funeral director: W. W. Chambers Company

Address: 3072 M St. N.W. Washington, D.C.

19. 11-11 1940 (Date rec'd by registrar) J. J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 11th 1940, at 2:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__, to ____ 19__, and that I last saw h____ alive on ____ 19__.

Immediate cause of death: Gun shot wound of Right upper sudden chest

Due to: Internal hemorrhage

Due to: + possible injury to Cardio Respiratory Centre

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: 11/11/40

Where did injury occur? South Haven Beach AA Co Md (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): highway - auto

Means of injury: Gun accident by self. Injured at work?

23. SIGNATURE: J. Oliver Purvis DME M. D. of other

Address: Annapolis Md Date signed: 11/11/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 (T) (I) (M)

RECEIVED
DEC 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(940)

11340

CERTIFICATE OF DEATH

Reg. Dist. No. 25

1. PLACE OF DEATH:

County Anne Arundel

City or town Brooklyn Md

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Ritchieway opp Cedar Hill

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 21 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Anne Arundel

City or town Brooklyn Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. Ritchie Highway opp Cedar Hill

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Gustav A Schatzschneider

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	W	Married

6 (b) Name of husband or wife Catherine

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 5 1871

8. AGE:

Years	Months	Days	If less than one day
69	1	4	hrs. min.

9. Birthplace Germany (Town, county, and state)

10. Usual occupation Stone Cutter

11. Industry or business Tombstone

FATHER

12. Name August Schatzschneider

13. Birthplace Germany

MOTHER

14. Maiden name Dont Know

15. Birthplace Germany

16. Informant Mrs Catherine Schatzschneider

Address Ritchie Highway, Brooklyn

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 13 1940 (month) (day) (year)

Cemetery or crematory Baltimore

Location East North Ave Ext

18. Funeral director William M Mareck

Address 715 Light St

19. Nov 11 1940 (Date rec'd by registrar) Ida M Whitson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 9 1940, at 6 45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/9 1940, to 11/9/40 19

and that I last saw him ~~alive on~~ dead on arrival 19

Immediate cause of death

Due to Coronary Occlusion

Due to

Other conditions Glaucoma of rt eye

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Samuel Aubin M. D. or other

Address 203 Collapsed ave Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

M

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RECEIVED
NOV 15 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (119-a)

CERTIFICATE OF DEATH

11341

Reg. Dist. No. 27

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Ft. George G. Meade, Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Station Hospital

Stay in hospital or inst. (yrs., or mos., or days): One day

Stay in this community (yrs., or mos., or days): 2 mos 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Odenton Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. -
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR -

3. (a) FULL NAME: Michael Shehan

3. (b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	-

6 (b) Name of husband or wife: -

6(c) If alive, give age - years

7. Birth date of deceased (mo., day, yr.): Aug. 16, 1940

8. AGE: Years	Months	Days	If less than one day
-	2	17	- hrs. - min.

9. Birthplace: Ft. Geo. G. Meade, Md.,
(Town, county, and state)

10. Usual occupation: -

11. Industry or business: -

FATHER
12. Name: Orville Shehan
13. Birthplace: Irwin, Tenn.

MOTHER
14. Maiden name: Laura Francis Jones
15. Birthplace: Bristol, Va.

16. Informant: Orville Shehan
Address: Odenton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 4, 1940 (month) (day) (year)

Cemetery or crematory: Cemetery

Location: Ft Geo G Meade, Md.

18. Funeral director: Post Quartermaster

Address: Ft Geo G Meade, Md.

19. Nov 4 (Date rec'd by registrar) 19 40 D.P. CARD, Colonel, MC Registrar

MEDICAL CERTIFICATION 10:35AM

20. DATE OF DEATH: November 2 19 40, at / M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 2 19 40, to Nov 2 19 40, and that I last saw him alive on Nov 2 19 40.

Immediate cause of death	DURATION
Inanition	Oct.
Due to Gastro-enteritis. Cause & Duration: six weeks.	21st.
Due to	1940
Other conditions: Physician did not see patient until just before death. Dehydration	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Edwin E. Corcoran
EDWIN E. CORCORAN, 1st Lt. MC D.D. or Coroner
Address: Ft Geo G. Meade, Md. Date signed

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DEC 3 1940
BUREAU V. S.

VS A15 MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (49-A)

11342

CERTIFICATE OF DEATH

Reg. Dist. No. 22

1. PLACE OF DEATH:

County: Anne Arundel County

City or town: Hanover
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Jessup Ridge Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Anne Arundel

City or town: Hanover
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Jessup Ridge Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: ROSIE C. SHIPLEY

3. (b) Social Security Number

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widow

6.(b) Name of husband or wife: Wm. Elbridge Shipley

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): December 17, 1877

8. AGE: Years: 62 ye Months: 10 Days: 16 If less than one day ..... hrs. ..... min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Schmoll
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden name: Kresser
15. Birthplace: Baltimore, Maryland

16. Informant: Miss Bessie Shipley
Address: Hanover, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 11/6/40 (month) (day) (year)

Cemetery or crematory: Friendship

Location: Friendship, Maryland

18. Funeral director: Wm. J. Tickner & Sons,
Address: North & Pa. Avenues

19. Nov 5 1940 (Date rec'd by registrar) Clara M. Hasbeck Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 3, 1940, at 9:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1st 1940, to Nov. 3rd 1940 and that I last saw her alive on Nov. 3rd 1940

	DURATION
Immediate cause of death: Teratoma of Left ovary	9 mos.
Due to: Abdominal Carcinomatosis	3 mos.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: Frank Shipley, M.D. M. D. or other

Address: Savage, Md. Date signed: 11/4/40

RECEIVED
NOV 11 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(8)

11343

CERTIFICATE OF DEATH

Reg. Dist. No.....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County..... A. A.

City or town..... Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:

..... Emergency Hosp.

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md. County..... A. A.

City or town..... Bend Gate

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME Simmons

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
—	— W	—

6.(b) Name of husband or wife..... —

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days | If less than one day

about 1m | ..... hrs. ..... min.

9. Birthplace..... Annapolis

(Town, county, and state)

10. Usual occupation..... —

11. Industry or business

FATHER

12. Name..... Robert F. Simmons

13. Birthplace

MOTHER

14. Maiden name..... Helen C. H[illegible]

15. Birthplace Annapolis

16. Informant..... Death certificate

Address

17..... Date thereof.....

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....

Location .....

18. Funeral director.....

Address

19. ..... 19.....

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Nov. 25 19 24, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19....., to..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death.....	DURATION
.....	.....
.....	.....
Due to.....	.....
.....	.....
Due to.....	.....
.....	.....
Other conditions.....	.....
.....	.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide..... Date of .....

Where did injury occur? .....

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury Injured at work?

23. SIGNATURE.....

M. D. or other

Address..... Date signed.....

MARYLAND STATE DEPARTMENT OF HEALTH

11344

2411 N. Charles St., Baltimore 140c

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: A.A.
City or town: Annapolis, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 Days
Hospital, institution, or street address where death occurred:
Emergency Hospital
How long in hospital or institution? 6 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Mayland County: A.A.
City or town: Best Gate
(If outside city or town limits, write RURAL and give nearest town)
Street No.: None
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Helen C. Simmons

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: Robert F. Simmons
6.(c) If alive, give age: 38 years

7. Birth date of deceased (mo., day, yr.): Dec 16 1914

8. AGE: Years	Months	Days	If less than one day
25	11	11	...hrs. ...min.

9. Birthplace: Annapolis, Md.
(Town, county, and state)
10. Usual occupation: House Wife
11. Industry or business: X

FATHER
12. Name: Frederick W. Hambruch
13. Birthplace: Germany

MOTHER
14. Maiden name: Margaret C. Knapp
15. Birthplace: Baltimore, Md.

16. Informant: Mrs. Theodore M. Heck
Address: 313 Linden Ave. Homewood. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 28 1940 (month) (day) (year)
Cemetery or crematory: Cedar Bluff
Location: Annapolis, Md.

18. Funeral director: B.L.Hopping
Address: Annapolis, Md.

19. November 28th 1940 (Date rec'd by registrar) O. J. J Wembley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 25 1940, at 9:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 20 1940, to Nov 25 1940
and that I last saw h[illegible] alive on Nov 25 1940

Immediate cause of death	DURATION
Generalized Peritonitis	5 days.
Due to: Self induced abortion	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: George C Basil
M. D. or other
Address: Annapolis Md. Date signed: 11-27-40

RECEIVED
DEC 5 1940
BUREAU V. S.

11345

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (172)

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Chesapeake Bay Anne Arundel

City or town: near Annapolis (Sandy Point)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? —

Hospital, institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 702 Shady Nook Road
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: George Gardner Smith III Jr.

3.(b) Social Security Number: 213-12-0841

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug 5th 1917

8. AGE:

Years	Months	Days	If less than one day
23	3	13	hrs. min.

9. Birthplace: Halethorpe Md.
(Town, county, and state)

10. Usual occupation: machine operator

11. Industry or business: Air-plane factory

FATHER
12. Name: George G. Smith, Jr.
13. Birthplace: Halethorpe, Maryland

MOTHER
14. Maiden name: Mary Barrett.
15. Birthplace: Baltimore, Md

16. Informant: Eugene Smith
Address: Boulevard Park Pasadena, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory: Lorraine Cemetery

Location: Balto Md

18. Funeral director: Frank H. Newell Inc.
Address: Pikesville Md.

19. 11-19 1940 (Date rec'd by registrar) J. J. Marshall (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 18 1940, at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ Post mortem examination 19—
~~and that I last saw the deceased on~~ Nov. 18 1940

Immediate cause of death: Drowning

Due to:

Due to: Capsizing of Sail-boat in Chesapeake Bay.

Other conditions:

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accidental Date of: 11/18/40

Where did injury occur? Chesapeake Bay off Sandy Point Light (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): in Chesapeake Bay

Means of injury: capsized Sail-boat Injured at work? no

23. SIGNATURE: John M. Claffey Deputy Medical Examiner (M. D. or other)

Address: Annapolis Md Date signed: 11/18/40

VS A15 (T) MARGIN RESERVED FOR BINDING (I)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 23 1940
BUREAU V S

11346

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

92d

CERTIFICATE OF DEATH

Reg. Dist. No. 25

1. PLACE OF DEATH:

County Anne Arundel

City or town Solley Md
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Marley Rd

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 50 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County A. A. Co

City or town Solley Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. Marley Rd
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Lillie E Solley

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
F. Male	White	Widow

6 (b) Name of husband or wife James W

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 24 1864

8. AGE: Years	Months	Days	If less than one day
76	8	20	hrs. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual occupation House work at home

11. Industry or business

FATHER
12. Name John G Moreland
13. Birthplace Scotland

MOTHER
14. Maiden name Josephine Ijams
15. Birthplace Md

16. Informant Mr Norman E Solley
Address Marley Neck Rd.

17. Burial Date thereof Nov 17 - 40
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Solley Home Cemetery

Location Solley

18. Funeral director William M Mareck
Address 715 Light St

19. Nov 16 1940 Ida M Whitsom
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 14 1940, at 4:10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/23/40 19 , to 11/14/40 19 ,
and that I last saw her alive on 11/13/40 19

Immediate cause of death — DURATION

Cerebral hemorrhage — 1 day

Due to

Due to Chronic Myocarditis, Chronic Endocarditis, Arteriosclerosis — Unknown

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Dt operations

Dt autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John [illegible] M. D. or other

Address Glen Burnie Date signed 11/14/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
DEC 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

11347

Reg. Dist. No. 23

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel.
City or town: Glen Burnie.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 100 Oak Lane.
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 3 years.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland. County: Anne Arundel.
City or town: Glen Burnie. Md. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 100 Oak Lane.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Mary Magdalene Steinbach

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female.	White.	Widowed.

6 (b) Name of husband or wife: Wm. Edw. Steinbach
6(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Feb 16, 1863

8. AGE:

Years	Months	Days	If less than one day
77	9	17	hrs. min.

9. Birthplace: Pennsylvania.
(Town, county, and state)
10. Usual occupation: Housewife.
11. Industry or business: At home.

FATHER
12. Name: Ignatius Ziegler
13. Birthplace: France

MOTHER
14. Maiden name: Sarah Sophia Frey.
15. Birthplace: Pennsylvania.

16. Informant: Mrs. Chas. M. Lake
Address: Glen Burnie. Md.

17. Philadelphia. (Burial, cremation, or removal? Which?) Date thereof: Nov 13, 1940 (month) (day) (year)
Cemetery or crematory: Forest Hills Cem.
Location: Philadelphia Pa.
18. Funeral director: Wm J Lawrence Sons
Address: Baltimore, Md

19. Nov 14 1940 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 9. 1940, at 7½ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1 1940, to Nov 9 1940, and that I last saw h-e alive on Nov. 8 1940.

Immediate cause of death	DURATION
Cerebral Hemorrhage	4 week.
Due to Arterio Sclerosis &	2 years
chronic Interstitial Nephritis	2 years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: James S. Billingsley M. D. or other
Address: Glen Burnie. Md. Date signed: Nov 9, 1940.

RECEIVED
DEC 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

11348

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:

County: a. a.

City or town: Shorelands

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Rural Glen Burnie, Md.

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 50 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: a.a

City or town: Shorelands Ward No.:

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Rural Glen Burnie

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Joseph Stephanowski

3. (b) Social Security Number:

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Eva M. Stephanowski

6(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): Jan. 2, 1874

8. AGE: Years: 66 Months: 10 Days: 14 If less than one day: hrs. min.

9. Birthplace: Lithuania (Town, county, and state)

10. Usual occupation: Tailor.

11. Industry or business: Clothing

FATHER

12. Name:

13. Birthplace: Lithuanian

MOTHER

14. Maiden name:

15. Birthplace: Lithuanian

16. Informant: Mrs Eva. Stephanowski

Address: R. F. D. Brooklyn, Md

17. (Burial, cremation, or removal. Which?) Date thereof: 11/19/40 (month) (day) (year)

Cemetery or crematory: Cedar Hill

Location: Brooklyn, A. A. Co Md

18. Funeral director: F. B. Wippert

Address: 300 Eutaw Place

19. Nov 16 1940 (Date rec'd by registrar) Mrs DeAlba Dep Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 16, 1940, at 2A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 15, 1940, to Nov. 16, 1940, and that I last saw him alive on Nov. 15, 1940.

Immediate cause of death: Cerebral Hemorrhage — DURATION: 2 days.

Due to: arteriosclerosis — 1 yr.

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: None Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Harry M. Moore M.D. M. D. or other

Address: Glen Burnie, Md. Date signed: Nov 16 1940.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 18 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11349

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Parole
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Parole
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Perlin Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Still Birth Taylor

3.(b) Social Security Number:

4. Sex: M
5. Color or race: Col.
6.(a) Single, married, widowed, or divorced:
6.(b) Name of husband or wife:
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Nov. 20, 1940
8. AGE: Years | Months | Days | If less than one day: hrs. min.
9. Birthplace: Parole Anne Arundel Co Md (Town, county, and state)
10. Usual occupation:
11. Industry or business:

FATHER
12. Name: William Taylor
13. Birthplace: Birdsville Md

MOTHER
14. Maiden name: Harriet Smothers
15. Birthplace: West River Fothan Md.

16. Informant: William Taylor
Address: Parole Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 20, 1940 (month) (day) (year)
Cemetery or crematory: Brewer Hill
Location: On Washington Rd. outside Annapolis Md
18. Funeral director: Chas. H. Alexander
Address: 43 and 45 Northwest St Annapolis Md.
19. Nov 21 1940 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 20th 1940 at 1:30 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from only on 19 Nov 20th to 19 40
and that I last saw h[illegible] alive on 19

Immediate cause of death	DURATION
Premature (Still Born)	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: R. L. Richardson M. D. or other
Address: Annapolis Md. Date signed: 11/20/40

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
DEC 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (30-B)

CERTIFICATE OF DEATH

11350

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 4 months, 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Gaithersburg
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Unknown
(If rural, give LOCATION)

2.(a) If veteran, name war: ------

3.(a) FULL NAME
MAURICE TAYLOR

3.(b) Social Security Number
----

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	single

6.(b) Name of husband or wife: ---------

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1919

8. AGE: Years: 21 Months: Unknown Days: If less than one day ..... hrs. ..... min.

9. Birthplace: Unknown
(Town, county, and state)

10. Usual occupation: Unknown

11. Industry or business: Unknown

FATHER
12. Name: Basil Taylor
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Bired (Burial, cremation, or removal. Which?) Date thereof: Nov 24 1940 (month) (day) (year)

Cemetery or crematory: Cemetery

Location: Emerygrove Md

18. Funeral director: Robert L. Snouder

Address: Rockville Md

19. Nov 22 1940 (Date rec'd by registrar) E. F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 22nd 1940, at 6:50A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 6th 1940, to Nov. 22 1940 and that I last saw him alive on Nov. 22 1940

Immediate cause of death: General paralysis of the insane — DURATION

Due to:

Due to: Lues

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: ------

Date of op.

Autopsy results: ----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ---- Date of

Where did injury occur? (City or town) (County) (State) ------

Injured at home, farm, industry, public place (where?) -----

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Crownsville, Md. Date signed: 11/22/40

VS A15 MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
DEC 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

11351

Reg. Dist. No. 27

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Fort George G. Meade, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? About 6 hours

Hospital, Institution, or street address where death occurred:
Fort George G. Meade,

How long in hospital or Institution? Not hospitalized

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 2007 West Mulberry St.
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3. (a) FULL NAME: GEORGE ANDREW TRAINOR

3. (b) Social Security Number: 218076310

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mollie Trainor

6.(c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): Feb. 2, 1879

8. AGE: Years	Months	Days	If less than one day
61	9	20	- hrs. - min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Plumber

11. Industry or business: ---

FATHER
12. Name: Francis P. Trainor
13. Birthplace: Va.

MOTHER
14. Maiden name: Josephine Hilmer
15. Birthplace: Baltimore, Md.

16. Informant: William M. Trainor
Address: 1921 West Landvale St., Balto, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 22, 1940 (month) (day) (year)

Cemetery or crematory:
Location: Baltimore, Md.

18. Funeral director: Thomas J. Kenny,
Address: 1600 Hollis St., Baltimore, Md.

19. Nov 22 1940 (Date rec'd by registrar)

D. P. Card, Col., MC
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 22 1940, at 1 15 P.M.

21. I CERTIFY that death occurred on the date above stated; Post-mortem Examination

[illegible] 19

Immediate cause of death	DURATION
Coronary Thrombosis	sudden
Due to: Arterio-sclerosis	unknown
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: John M. Claffy Deputy Medical Examiner
M. D. or other

Address: Annapolis, Md. Date signed: 11/22/40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
NOV 29 1940
BUREAU V. S.

(M)

(C)

(I)

(T)

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

11352

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 mo.

Hospital, institution, or street address where death occurred: Emergency Hospital, Annapolis, Md.

How long in hospital or institution? one day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: A. A.

City or town: Crownsville P.O., Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Gorfrey Richard Trapp

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife: --

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 7, 1940

8. AGE:

Years	Months	Days	If less than one day
	6	5	..... hrs. ..... min.

9. Birthplace: Annapolis, Md.
(Town, county, and state)

10. Usual occupation: --

11. Industry or business

FATHER
12. Name: William Gerber Trapp
13. Birthplace: Crownsville, Md.

MOTHER
14. Maiden name: Dorothy Louise Hess
15. Birthplace: Crownsville, Md.

16. Informant: William Gerber Trapp
Address: Crownsville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 14/40 (month) (day) (year)

Cemetery or crematory: St Stephens

Location: Millersville. Md

18. Funeral director: B L Hopping

Address: Annapolis Md.

19. Nov 14 1940 (Date rec'd by registrar) J J Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 12, 1940, at 9:10 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 7, 1940, to Nov. 12, 1940 and that I last saw him alive on Nov. 12, 1940

Immediate cause of death	DURATION
bilateral bronchopneumonia	
Due to aspiration	
Due to asphyxiation ?	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Samuel Bornuch M.D. M. D. or other

Address: Annapolis. Md Date signed: 11/13/40

RECEIVED
DEC 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

11353

Reg. Dist. No. 7

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Emergency Hospital
How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 85 Prince Geo St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Evelyn Virginia Tucker

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov 29th 1939 DEC.

8. AGE: Years	Months	Days	If less than one day
	11	21	hrs. min.

9. Birthplace: Annapolis Md
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER 12. Name: Nelson Tucker
13. Birthplace: Calvert Co Md.

MOTHER 14. Maiden name: Elsie Collins
15. Birthplace: Annapolis Md

16. Informant: Elsie Tucker
Address: 85 Prince Geo. St. Annapolis Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 22nd 1940 (month) (day) (year)
Cemetery or crematory: Cedar Bluff
Location: Annapolis Md.

18. Funeral director: John M Taylor
Address: Annapolis Md.

19. 11 22 1940 (Date rec'd by registrar) J J Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 20 1940 at 10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 18 1940 to Nov 20 1940 and that I last saw h[illegible] alive on Nov 20 1940

Immediate cause of death	DURATION
Bilateral Bronchial Pneumonia	3 days
Due to	
Due to	
Other conditions Malnutr. two	10 months

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: George C Bond M. D. or other
Address: Annapolis Date signed: 11-22-40

RECEIVED
DEC 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

11354

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 mo. 20 days

Hospital, institution, or street address where death occurred: Crownsville State Hospital

How long in hospital or institution? 1 mo. 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 619 Para St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Edward Turner (Dr)

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Charlotte

6.(c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.): 1880 (?)

8. AGE: Years	Months	Days	If less than one day
60 (?)	?	?	...hrs. ...min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Fertilizer Plant

FATHER 12. Name: Louis Turner

13. Birthplace: Virginia

MOTHER 14. Maiden name: Luzanne ?

15. Birthplace: Virginia

16. Informant: Hospital Records

Address: Crownsville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 7 1940 (month) (day) (year)

Cemetery or crematory: Mt. Calvary Cemetery

Location: Anne Arundel County

18. Funeral director: A. Halstead

Address: 918 Druid Hill Ave. Baltimore

19. 11-3-40 19... E. F. Joyce Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 3 1940 at 6 00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 12 1940 to Nov. 3 1940

and that I last saw him alive on Nov. 3 1940

	DURATION
Immediate cause of death: Cerebral Hemorrhage	48 hrs.
Due to: Generalized arteriosclerosis	unknown
Due to:	
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of —

Where did injury occur? (City or town) (County) (State) —

Injured at home, farm, industry, public place (where?) —

Means of injury Injured at work?

23. SIGNATURE Alex P. Harrison M.D.

M. D. or other

Address Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

NOV 6 1940
BUREAU V. S.

VS A15 (T) (I) (M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (168)

11355

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Jessups
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? not known

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: unknown County: Unknown

City or town: unknown
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Unknown

3.(b) Social Security Number: unknown

4. Sex: female

5. Color or race: white

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years: about 40 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace: unknown
(Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER
12. Name: —
13. Birthplace: —

MOTHER
14. Maiden name: —
15. Birthplace: —

16. Informant

Address

17. Burial
(Burial, cremation, or removal. Which?)

Date thereof: Nov. 22, 1940
(month) (day) (year)

Cemetery or crematory: Marley Med. Church yard

Location: Anne Arundel Co.

18. Funeral director: Thomas W. Swigleton

Address: Glen Burnie, Md.

19. Nov. 22 1940
(Date rec'd by registrar)

Matilda R. DeAlba
Dep. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: unknown 19..., at ... M

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~
Post-mortem examination
~~and that last saw it alive on~~ Nov. 21 1940

Immediate cause of death: Homicide

Due to: (Body badly decomposed. Had been dead about 2 months.

Due to: Was found in woods covered with twigs and pine needles)

Other conditions

(Include pregnancy within 8 months of death)

DURATION

Major findings of operations

Date of op.

Autopsy results: reports will be furnished later

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Homicide Date of: unknown

Where did injury occur? unknown, as body was almost naked and was probably carried to woods where it was found
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: unknown, Injured at work?

23. SIGNATURE: John McCaffy Deputy medical examiner
M. D. or other

Address: Annapolis, Md Date signed: 11/21/40

RECEIVED
DEC 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

11356

Reg. Dist. No. 21

1. PLACE OF DEATH:

County a a

City or town annapolis md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County a a

City or town Annapolis Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. West & Cathedral

(If rural, give LOCATION)

2.(a) If veteran, name war None

3.(a) FULL NAME James L. Valentine

3.(b) Social Security Number 214-10-0009

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
m	w	widower

6.(b) Name of husband or wife Unknown

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Unknown 1878.

8. AGE: Years 62 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace New Jersey (Town, county, and state)

10. Usual occupation Clerk

11. Industry or business P. W. A.

FATHER 12. Name Unknown

13. Birthplace Unknown

MOTHER 14. Maiden name Unknown

15. Birthplace Unknown

16. Informant Relief Asst. Address at Annapolis - Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 11/40 (month) (day) (year)

Cemetery or crematory Cedar Bluff

Location Annapolis - Md.

18. Funeral director B. L. Hopkins

Address Annapolis Md.

19. Nov 11th 1940 (Date rec'd by registrar) J. M. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 7 1940 at 8 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 5th 1940 to Nov 7 1940

and that I last saw him alive on Nov 7 1940

Immediate cause of death	DURATION
Coronary Thrombosis	Nov 5th
Due to Arteriosclerosis	Unknown
Due to Hypertension (chr.)	unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George C Bond M. D. or other

Address Annapolis Md Date signed 11-9-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
DEC 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11357

46-B

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Eastport
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Eastport
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 429 Burnside St.
(If rural, give LOCATION)

2.(a) If veteran, name war: Spanish American

3. (a) FULL NAME: Sheldon R. Van Houter

3. (b) Social Security Number:

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Mary A. Van Houter

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 31st 1879

8. AGE: Years 61 Months 5 Days 8 If less than one day ..... hrs. ..... min.

9. Birthplace: Du Bois Penn.
(Town, county, and state)

10. Usual occupation: Ret. from U.S. Army

11. Industry or business: Master at Arms

FATHER
12. Name: Peter Van Houter
13. Birthplace: Penn.

MOTHER
14. Maiden name: Martha J. Phillips
15. Birthplace: Penn

16. Informant: Mary A. Van Houter
Address: 429 Burnside St Eastport

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 12-1940 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Virginia

18. Funeral director: John M. Taylor
Address: Annapolis Md.

19. November 9th 1940 (Date rec'd by registrar) J. J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 8 1940, at 10 30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1940, to Nov 8 1940 and that I last saw him alive on Nov 7th 1940

Immediate cause of death: Carcinoma Stomach with Metastasis to Intestine & Liver

Due to: Acute obstruction Jaundice

Other conditions

DURATION: Several months; 1 month

(Include pregnancy within 3 months of death)

Major findings of operations: Intestinal obstruction due to Carcinoma Date of op. August

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: George C Basil M. D. or other

Address: Annapolis Md Date signed: 11-9-40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 23 1946
BUREAU V S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92d)

11358

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:

County Anna Arundel

City or town Glen Burnie

(If outside city or town limits, write RURAL NEAR and give town)

Street address, ~~hospital, or institution~~: 305 Light st Rd

Stay in hospital or inst. (yrs., or mos., or days) ~~6 yrs~~

Stay in this community (yrs., or mos., or days) 6 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County A A Co

City or town Glen Burnie Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 305 Light St Rd

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Margaret Ann Wade

3. (b) Social Security Number

4. Sex F. Male

5. Color or race White

6. (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife James F.

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Sept 25 1860

8. AGE: Years 80 Months 1 Days 22 If less than one day ____ hrs. ____ min.

9. Birthplace Md (Town, county, and state)

10. Usual occupation House work at home

11. Industry or business

FATHER 12. Name William Wheeler

13. Birthplace Md

MOTHER 14. Maiden name Eliza Stinchcomb

15. Birthplace Md

16. Informant Mrs Carrie S Stone

Address 305 Light st Rd. Glen Burnie Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 19, 1940 (month) (day) (year)

Cemetery or crematory Cedar Hill Cemt.

Location A. A. Co. Md.

18. Funeral director William M. Mareck

Address 715 Light St Baltimore. Md.

19. Nov. 16 1940 (Date rec'd by registrar) McDeAlva Dep. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 16 1940, at 1:30 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 8 1940, to Nov. 16 1940, and that I last saw her alive on Nov 15 1940.

Immediate cause of death Chronic Valvular Disease of the Heart. Influenza

Due to Arterio Sclerosis

Due to

Other conditions —

(Include pregnancy within 3 months of death)

Major findings: —

Of operations

Of autopsy —

DURATION: 3 years. 5 days. 3 years.

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James S. Billingsley M. D. M. D. or other

Address Glen Burnie. Md Date signed Nov 18 1940

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
DEC 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11359

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: A.A.
City or town: Annapolis. Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 Years
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: A.A.
City or town: Annapolis, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 117 Smith Ave
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Arie B. Walsh

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: James F. Walsh
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov 18 1853

8. AGE: Years	Months	Days	If less than one day
86	11	20	hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: None
11. Industry or business

FATHER
12. Name: William B. Walsh
13. Birthplace: Unknown

MOTHER
14. Maiden name: Mary Mattingly
15. Birthplace: Maryland

16. Informant: Frank B. Walsh
Address: Annapolis, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov9 1940 (month) (day) (year)
Cemetery or crematory: Mount Olivet
Location: Washington, D.C.

18. Funeral director: B.L.Hopping
Address: Annapolis, Md.

19. Nov 9 1940 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 7 1940, at 4 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1938, to Nov 7 1940
and that I last saw h.er alive on Nov 6 1940

Immediate cause of death	DURATION
Myocarditis & Myocardial Insufficiency	4 yrs
Due to: Arteriosclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: George C Boul M. D. or other
Address: Annapolis Md Date signed: 11-8-40

RECEIVED
DEC 5 1940
JUNEAU, ALASKA

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11360

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Crownsville State Hospital

How long in hospital or institution? 1 yr. 3 mos. 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore City (If outside city or town limits, write RURAL and give nearest town)

Street No.: 1710 N. Carey Street (If rural, give LOCATION)

2.(a) If veteran, name war: ------

3.(a) FULL NAME: ELIZABETH WASHINGTON

3.(b) Social Security Number: -------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	married

6.(b) Name of husband or ~~wife~~ John Washington

6.(c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.): 1913

8. AGE: Years 27 | Months Unknown | Days | If less than one day ..... hrs. ..... min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: -----

FATHER
12. Name: John Kelly
13. Birthplace: Virginia

MOTHER
14. Maiden name: (Unknown) Cosby
15. Birthplace: Virginia

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. (Burial, cremation, or removal. Which?) Date thereof: V 25-40 (month) (day) (year)

Cemetery or crematory: Mt Calvary.

Location:

18. Funeral director: Adolphus Halstead

Address: 9 18 Bond Hill Ave

19. H/23 1940 (Date rec'd by registrar) E. F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 22nd 1940, at 5:25A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 31st 1939, to Nov. 22nd 1940 and that I last saw her alive on Nov. 22nd 1940

Immediate cause of death: Pulmonary tuberculosis

Due to:

Due to:

Other conditions: -------

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations: -----

--- Date of op.

Autopsy results: -----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: ---- Date of: -------

Where did injury occur? (City or town) (County) (State) -------

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Crownsville, Md. Date signed: 11/22/40

#6482

Elizabeth Washington
Baltimore City
Admitted July 31st, 1939
Died Nov. 22nd, 1940

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore 93-d

Reg. Dist. No. 23 / 23

11361

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

(a) County Anne Arundel

(b) City or town McPherson Station (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: ~~[illegible]~~ - Dorsey Rd.

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days) 51 yrs.

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Md. (b) County Anne Arundel

(c) City or town Brooklyn R.F.D. #9 - (If outside city or town limits, write RURAL and give town)

(d) Street No. NW Dorsey Road. (If rural give location)

(e) If foreign born, how long in U. S. A.? _____ years

3 (a) FULL NAME Clara Hanson Wheat

3 (b) If veteran, name war —

3 (c) Social Security No. None

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. married -

6 (b) Name of husband or wife Chas. Louis Wheat

6. (c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) Sept. 27 - 1868

8. AGE: Years 72 Months 1 Days 10 If less than one day _____ hr. _____ min.

9. Birthplace Dorsey Md. (Town, county, and state)

10. Usual occupation Hco.

11. Industry or business none

FATHER
12. Name Henry Hood -
13. Birthplace Howard Co. Md.

MOTHER
14. Maiden Name Henrietta Bryan
15. Birthplace Howard Co. Md.

16 (a) Informant Charles L. Wheat
(b) Address Brooklyn R.F.D. #9

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Nov. 9, 1940 (month) (day) (year)
(c) Cemetery or crematory Friendship Cem.
Location A. A. Co.

18 (a) Funeral director Thomas W. Singleton
(b) Address Glen Burnie, Md.

19 (a) Nov. 8 / 40 (Date rec'd by registrar) (b) M. DeAlba Dep. Registrar

MEDICAL CERTIFICATION

20. Date of death Nov. 7 1940, at 7:10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1937, to Nov. 7 1940, and that I last saw him alive on Nov. 7 1940

Immediate cause of death	Duration
Cardio - Vascular Disease	1937
Due to (Tentative diagnosis of Brain tumor - but not proven)	
Due to	
Other conditions Hypertension	1936 -

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas. L. Ball, Jr. MD (M. D. or other)

Address Linthicum, Md Date signed 11-7-40

VS. A15 MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
DEC 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

11362

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Magothy Beach
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 Years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Magothy Beach Severna Park R.D.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Note: This person was christened Florence Lillian but always used as stated
Lillian Florence Wiechman (Nee Norton)

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: John H. Wiechman
6.(c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): March 4, 1887

8. AGE: Years	Months	Days	If less than one day
53	8	X	hrs. min.

9. Birthplace: Washington D.C.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Own Home
FATHER 12. Name: Unknown
13. Birthplace: Unknown
MOTHER 14. Maiden name: Unknown
15. Birthplace: Unknown
16. Informant: Mr. John H Wiechman
Address: Severna Park. R.D.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: December 3, 1940 (month) (day) (year)
Cemetery or crematory: Glen Haven Memorial Park.
Location: Glen Burnie, A.A. Co. Md.
18. Funeral director: Thomas W. Singleton
Address: Glen Burnie, Md.
19. Dec. 2 1940 (Date rec'd by registrar) Mae Allen Dep Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 30 1940, at 9.05 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from MAY 24 1940, to DEC NOV 30 1940 and that I last saw him ALIVE on NOV. 30. 1940. 19

Immediate cause of death	DURATION
DIABETIC COMA	2 DAYS
CARBUNCLE (NECK)	
Due to: DIABETES MELLITUS	UNKNOWN
Due to:	
Other conditions: CHRONIC ENDOCARDITIS	UNKNOWN
ARTERIO-SCLEROSIS	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: John Alexander, M. D. or other
Address: Glen Burnie Date signed: DEC 1st 40

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JAN 6 1941
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VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

11363

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Eastport, Md.

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: A.-A.

City or town: Eastport Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Agusta E. Wilde

3. (b) Social Security Number

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Carl F. Wilde

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Sept 8 1862

8. AGE: Years: 78 Months: 1 Days: 11 If less than one day ____ hrs. ____ min.

9. Birthplace: Germany (Town, county, and state)

10. Usual occupation: House wife

11. Industry or business

FATHER

12. Name: Unknown

13. Birthplace: Germany

MOTHER

14. Maiden name

15. Birthplace: Germany

16. Informant: Mrs. C. F. Wilde

Address: Eastport

17. Burial (Burial, ~~cremation, or removal. Which?~~) Date thereof: Nov. 12 1940 (month) (day) (year)

Cemetery ~~or crematory~~: Quaker Cem. A.A. Co. Md.

Location: Galesville

18. Funeral director: V. A. Hardesty & Son

Address: Galesville Md.

19. 11-11 1940 (Date rec'd by registrar) J. J. Murphy Jr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 9 1940, at 11 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1 1940, to Nov 9 1940, and that I last saw her alive on Nov 9 1940.

Immediate cause of death: Cerebral Hemorrhage & left paraplegia

Due to: Hypertension Arteriosclerosis

Due to: Gangrene left foot

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION: 6 months; 1 month

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: George C Bond M. D. or other

Address: Annapolis Md. Date signed 11-11-40

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DEC 5 1940
BUREAU V. S.

11364

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (942)

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 years

Hospital, Institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No. 204 Duke of Gloucester
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Matlow Thompson Winchester

3.(b) Social Security Number

4. Sex: female

5. Color or race: white

6.(a) Single, married, widowed, or divorced: widowed

6.(b) Name of husband or wife: Thos. Chase Winchester

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug. 20. 1870.

8. AGE: Years 70 | Months 1 | Days 20 | If less than one day ..... hrs. ..... min.

9. Birthplace: Annapolis, Maryland
(Town, county, and state)

10. Usual occupation: not employed.

11. Industry or business

FATHER
12. Name: Major Wm Henry Thompson
13. Birthplace: Annapolis, Md.

MOTHER
14. Maiden name: Jane Anne Phillips
15. Birthplace: Annapolis, Md.

16. Informant: Mrs. Mary T. W. Fauble.

Address: 204 Gloucester St. Annapolis Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 13 1940 (month) (day) (year)

Cemetery or crematory: White Hall

Location: White Hall A A Co Md

18. Funeral director: John M. Taylor

Address: Annapolis Md.

19. 11 12 1940 (Date rec'd by registrar) J. J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 10 1940, at 9 30 A M

21. I CERTIFY that death occurred on the date above stated; ~~[illegible]~~ Post-mortem examination ~~[illegible]~~ 19

Immediate cause of death: Coronary occlusion — DURATION: Sudden

Due to

Due to

Other conditions

(include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: John M. Claffy Deputy Medical Examiner
M. D. or other

Address — Date signed 11/12/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

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NOV 23 1940
BUREAU V. S

11365

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Unknown

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis (If outside city or town limits, write RURAL and give nearest town)

Street No. 11 Feldmeyer Court (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Walter Young

3.(b) Social Security Number 214-05-0644

4. Sex: Male

5. Color or race: Col.

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Mary C. Young

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Feb 5, 1892

8. AGE: Years 48 48 | Months 9 | Days 3 | If less than one day ____ hrs. ____ min.

9. Birthplace: Annapolis Md. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER

12. Name: Erwine Young

13. Birthplace: Anne Arundel

MOTHER

14. Maiden name: Mary Jane Henderson

15. Birthplace: Anne Arundel Co.

16. Informant: Mary C. Young

Address: 11 Feldmeyer Court

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 11, 1940 (month) (day) (year)

Cemetery or crematory: Brewer Hill

Location: On Washington rd. outside Annapolis

18. Funeral director: Charles H. Alexander

Address: 43 and 45 Northwest Annapolis

19. 11/9 1940 (Date rec'd by registrar) J. J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11/8 1940, at 3:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 18 1940, to Nov. 8 1940 and that I last saw him alive on November 7 1940

Immediate cause of death	DURATION
Cardio Renal Disease	5 mo.
Due to	
Due to	
Other conditions: Pleurisy (Include pregnancy within 3 months of death)	2 mo.

Major findings of operations ____ Date of op. ____

Autopsy results ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: Lawrence W. Greene M. D. or other

Address: Annapolis, Md. Date signed: 11/9/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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DEC 5 1940
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